**Hydration/Dehydration Healthcare Plan**

| **Name:** | FirstName LastName | | | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- | --- | --- |
| **These are my diagnoses related to dehydration:** | | | List all diagnoses related to dehydration, or indicate if there are none. | | |
| **I am allergic to these things:** | | | List all known allergies and sensitivities, or indicate if there are none. | | |
| **The goal of this Healthcare Plan is:** | | | I won’t show any signs of dehydration for ## days/months.  I will not experience increased heart rate for ## days/months.  Describe any other goal related to hydration/dehydration. | | |
| **Progress in the past year:** | | | What has my hydration/dehydration status for the past year been as compared with the year prior? | | |
| **In an EMERGENCY**  **Call 911 IMMEDIATELY and begin CPR if I:**  **🡪 Become extremely lightheaded**  **🡪 Lose consciousness or become unresponsive**  **🡪 Am confused or have a sudden change in behavior**  **🡪 Have gray or pale skin or blue lips**  **🡪 Describe any additional instructions here.** | | | | | |
| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL**  **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** | | | | | |
| **When I am dehydrated, this is what usually happens:** | | | I urinate less.  My urine has a dark color and/or a strong odor.  My mouth is dry.  My skin is dry and/or my lips are cracked.  I am extremely thirsty.  I am unusually tired and/or I have a hard time waking up.  I am dizzy or lightheaded or weak.  I have lost weight.  My skin lacks elasticity (for example, when pulled gently at the wrist, it takes a while to return to original position).  Other: Describe any other things that happen to me when I become dehydrated, or indicate if there are none. | | |
| **Supporters should be aware that some conditions and circumstances make it more likely that I will have become dehydrated:** | | | I cannot tell you when I am thirsty.  I need help eating and drinking.  I take medication with a side effect of dehydration.  I have a health condition, such as diabetes or kidney disease, that makes dehydration more likely.  I sometimes refuse to eat or drink.  I drool a lot.  I frequently experience vomiting and/or diarrhea.  Other Describe any other things that make dehydration more likely, or indicate if there are none. | | |
| **This is how to help me remain adequately hydrated:** | | | Encourage me to drink plenty of fluids during the day.  Make sure I consume ## ounces or milliliters of fluid per day.  When I am having problems getting enough to drink, offer me foods with a high fluid content such as List examples of high fluid foods appropriate for me here, or indicate if this is not applicable.  Document my fluid intake.  Monitor the color of my urine and report to nursing if my urine appears dark and/or cloudy.  Document my urine output.  Make sure that I do not eat or drink these foods/liquids: list those foods/liquids here, or indicate if there are none.  Other Describe any other supports I need to remain hydrated, or indicate if there are none. | | |
| **If I become dehydrated, these are the things you should do to help me:** | | | Report any signs/symptoms of dehydration to the nurse as soon as you notice them.  Other Describe any other things that need to be done if I become dehydrated, or indicate if there are none. | | |
| **Documentation:** | | Describe where supporters should record fluid intake and any signs/symptoms of dehydration. | | | |
| **Nursing Intervention:** | | Describe those things that must be done by the nurse relative to dehydration, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. | | | |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** Yes No

RN Typed Name and Agency

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